Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services STATE OF IL COLLEGE CHOICE HEALTH PLAN (CCHP): Aetna



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>https://www.aetnastateofillinois.com/health-plans</u> or by calling 1-855-856-0038. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, provider, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-856-0038 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$750 per benefit recipient	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	Yes. \$250 per in-network hospital admission; \$500 per out-of-network hospital admission; \$400 per emergency room visit; \$250 for organ and tissue transplants.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$1,500 / Family \$3,000. Out-of- <u>Network</u> : Individual \$4,500 / Family \$9,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800- 370-4526 for a list of In- <u>Network</u> providers.	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

Common Medical Event	Services You May Need	Prov (You wil	What You twork vider I pay the ast)	Prov (You wil	Network vider I pay the ost)	Limitations, Exceptions & Other Important Information	
	Primary care visit to treat an injury or illness	20% <u>coins</u>		40% <u>coins</u>		None	
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit <u>Preventive care</u> / <u>screening</u> /immunization	20% <u>coins</u> No charge		40% <u>coins</u> 40% <u>coins</u>		None You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
	Diagnostic test (x-ray, blood work)	20% <u>coins</u>	surance	40% <u>coins</u>	<u>surance</u>	None	
lf you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coins</u>	<u>surance</u>	40% <u>coins</u>	<u>urance</u>	Requires <u>pre-authorization</u> . If necessary <u>pre-</u> <u>authorization is not obtained, benefits may be</u> reduced or not covered.	
If you need drugs to treat your		Tier 1	Tier 2	Tier 3	Specialty Tier		
illness or condition	Copayments (30 Day Supply)	\$12.50	\$25.00	\$50.00	\$100.00	**Medications received at CVS Caremark	
More information about <u>prescription</u>	Copayments (90 Day Supply)	\$25.00	\$50.00	\$100.00	\$200.00	Pharmacy or through CVS Caremark Mail Service Pharmacy. Deductible applies.	
drug coverage is available at www.caremark.com or call 1-877-232-8128	Maintenance Choice** (90 Day Supply)	\$12.50	\$25.00	\$50.00			
If you have	Facility fee (e.g., ambulatory surgery center)	20% <u>coins</u>	surance	40% <u>coins</u>	surance	None	
outpatient surgery	Physician/surgeon fees	20% coinsurance		40% coinsurance		None	
If you need	Emergency room care	20% <u>coins</u>		20% <u>coins</u>		Per visit deductible is waived if admitted.	
immediate medical	Emergency medical transportation	20% <u>coins</u>		20% coinsurance		None	
attention	<u>Urgent care</u>	20% <u>coins</u>	surance	40% <u>coins</u>	surance	None	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% coinsurance	None
If you need mental	Outpatient services	20% coinsurance	40% coinsurance	
health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	services. Maternity care may include tests and
lf you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> may be required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-</u> <u>authorization</u> is not obtained, benefits may be reduced or not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
If you need help	Habilitation services	20% <u>coinsurance</u>	40% coinsurance	None
recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-</u> <u>authorization</u> is not obtained, benefits may be reduced or not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% <u>coinsurance</u>	40% coinsurance	<u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
If your child needs	Children's eye exam	Not covered	Not covered	None
dental or eye care	Children's glasses	Not covered	Not covered	None

	Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the	ı Will Pay Out-of-Network Provider (You will pay the	Limitations, Exceptions & Other Important Information
		Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Cosmetic surgery	 Long-term care 	Routine foot care
Custodial care	 Private-duty nursing 	 Weight loss programs - Except for required preventive
Routine dental care	Routine eye care	services.
ther Covered Services (I imitations may a	upply to these services. This isn't a complete	te list. Please see vour plan document)
ther Covered Services (Limitations may a	pply to these services. This isn't a complet	te list. Please see your <u>plan</u> document.)
other Covered Services (Limitations may a Bariatric surgery	 pply to these services. This isn't a complete Non-emergency care when transmission 	

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

• Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038; or
- Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a
hospital delivery)

\$750

20%

20%

20%

The <u>plan's</u> overall <u>deductible</u>
Specialist Coinsurance
Hospital (facility) Coinsurance
Other <u>Coinsurance</u>

This EXAMPLE event includes services like: Specialist office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work*) Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	\$750
Copayments	\$0
Coinsurance	\$2,398
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,208

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-
controlled condition)

The plan's overall deductible	\$750
Specialist Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

Total Example Cost	\$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	\$750
Copayments	\$0
Coinsurance	\$1,326
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,096

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other Coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
Deductibles*	\$750	
Copayments	\$0	
Coinsurance	\$230	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$980	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-856-0038.

*Note: This <u>plan</u> has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> for specific services?" row above. *Note: Your deductible may be different than the examples depending on your annual salary. For your applicable deductible, see page 1 of this document.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-856-0038.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-855-856-0038 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-855-856-0038 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 856-0038-1-855
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-856-0038 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-856-0038 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-855-856-0038-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-856-0038 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-855-856-0038.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-855-856-0038 sin gåstu.
Cherokee -	ՅՅՆԴՅ ՏՅԻ ՅՅՆ ԴԻՅՆՆ ԴԻՅՆԻՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆ
Chinese -	欲取得繁體中文語言協助,請撥打1-855-856-0038,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-855-856-0038.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-856-0038.
French -	Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-855-856-0038 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-855-856-0038 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-856-0038.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-856-0038 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.
Japanese -	日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。
Karen -	လ၊ တါမာစားတါကတိုးကိုျဉ်အင်္ဂါ ကိုျဉ် ကိုး 1-855-856-0038 လ၊ တအိုဉ်ဒီးတါလ၊ ၁ဘူဉ်လ၊ ၁စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุuùň wɛ̃ɛ, dá 1-855-856-0038
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 856-856-855 به خوّر ايي پهيو مندي بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ -855-856-0038 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wōnān.
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais. សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរំ សូមទូរស័ព្ទទទៅកាន់លខេ 1-855-856-0038 ដហេយឥតគិតថ្លល់។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-856-0038
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- ⁸⁵⁵⁻⁸⁵⁶⁻⁰⁰³⁸ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-855-856-0038 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.
^P ersian - Polish -	بر ای ر اهنمایی به زبان فارسی با شماره 856-0038 I-855-856 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.

Portuguese -	Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.
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- Romanian Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-856-0038
- Russian Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.
- Samoan Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.
- Serbo-Croatian Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-856-0038.
- Spanish Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.
- Sudanic-Fulfude Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-856-0038. Njodi woo fawaaki on.
- Swahili Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.
- Telugu భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-855-856-0038 కు కాల్ చేయండి. (తెలుగు)
- Thai สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย
- Tongan Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-856-0038 'o 'ikai hā ōtōngi.
- Trukese Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-856-0038 nge esapw kamé ngonuk.
- Turkish (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-856-0038.
- Ukrainian Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.
- ارور Urdu ارور کا کتف م رب 855-856-0038 ا یک تن و اعمین اس و در Urdu -
- Vietnamese Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hấy gọi miến phi đên số 1-855-856-0038.
- Yiddish פאר שפראך הילף אין אידיש רופט 1-855-856-0038 פאר שפראך הילף אין אידיש רופט
- Yoruba Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.